



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

CENTER FOR PAIN MANAGEMENT  
2637 CORNERSTONE BLVD  
EDINBURG TX 78539

#### **Respondent Name**

MC ALLEN ISD

#### **Carrier's Austin Representative**

Box Number 19

#### **MFDR Tracking Number**

M4-11-3334-01

#### **MFDR Date Received**

June 2, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "I submitted three reconsideration [sic] to Anchor Claim for patient [injured employee]. Date Of [sic] Service 6-23-10, 7-6-10 & 10-20-10 for CPT CODE 64494 that was underpaid on all three claims as per 2010 Texas Workers Comp Fee Schedule and Medicare Guidelines. I received a denial for all these dates of services stating that the original payment decision is being maintained .That [sic] upon review, it was determined that the claims were process [sic] properly. I understand that multiple surgery rules apply for code 64494, but still my cpt [sic] code did not even paid [sic] 50% of the primary code which is 64493. Would like your assistance in this matter since I already tried appealing my claims and they are still coming back denied."

**Amount in Dispute:** \$303.03

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Self-insured assert that it correctly calculated reimbursement pursuant to these negotiated reimbursement."

**Response Submitted by:** Flahive, Ogden & Latson

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2010, July 6, 2010 and October 20, 2010	64494	\$303.03	\$27.24

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- Note: Multiple surgery rules allow for this procedure to be paid at 50%. Charge exceeds fee schedule allowance
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 59 – Processed based on multiple or concurrent procedure rule
- W1 – Workers Compensation State Fee Schedule Adjustment
- PPO Reductions based on agreement with Rockport
- Notes: Rockport Network: Rockport Healthcare grp;
- 18 – Duplicate claim/service
- Previously processed for reconsideration
- Note: MAR FOR CPT 64494 IS \$121.11 @ 50%=\$60.55-\$9.08 PPO=\$51.48

**Issues**

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

**Findings**

1. The insurance carrier reduced disputed services with reason code "45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on May 14, 2013 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." The requestor seeks additional reimbursement for CPT code 64494 rendered on June 23, 2010, July 6, 2010 and October 20, 2010.  
  
The requestor billed the following CPT codes on June 23, 2010 and July 6, 2010: 64493, 64494, 77003, S0020, J1030, J7040, J3010, J2250, A4550 and 99144  
  
The requestor billed the following CPT codes on October 20, 2010: 64493, 64494, J7040, J3010, J2250, A4550, 99144 and 36000.  
  
The division completed NCCI edits to identify edit conflicts that would affect reimbursement. The division finds that no NCCI edit conflicts were identified for CPT code 64494, as a result, reimbursement will be determined based on 28 Texas Administrative Code § 134.203 (c).
3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

Per 28 Texas Administrative Code § 134.203 “(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title.”

Per the CMS Multiple Procedure Payment Reduction (MPPR) surgery reduction policy: Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.”

The MAR reimbursement for CPT code 64494 is \$121.11, with the 50% reduction for MPPR the reimbursement amount is \$60.56/per date of service. The insurance carrier issued payment in the amount of \$51.48, therefore the requestor is entitled to additional reimbursement in the amount of \$9.08 x 3 dates of service for a total recommended amount of \$27.24.

Review of the submitted documentation finds that the requestor is entitled to a total reimbursement in the amount of \$27.24 for CPT code 64494 for dates of service June 23, 2010, July 6, 2010 and October 20, 2010.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$27.24.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$27.24 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
November 7, 2013  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**